EXHIBIT A

Medical Records Subpoenaed from Northwest Medical Center, Winfield, Alabama

Tommy D. Barron, Emergency Room, February 15, 2004.

STATE OF ALABAMA)

COUNTY OF MARION)

CERTIFICATE OF CUSTODIAN OF MEDICAL RECORDS

I, Vicky Finch hereby certify and affirm that I am the Medical Records Technician of Northwest Medical Center, a hospital organized or operated pursuant to or under the Laws of Alabama, located at Winfield, Marion County Alabama, that I am custodian of the hospital records of said hospital and that the within copy of said hospital records are an exact, full, true and correct copy of said hospital records pertaining to Tommy Barrow AKA Taz Days Birth

I, Vicky Finch further certify that I am the custodian of said medical records, that the original of said hospital records were made and kept in the usual and regular course of business of the hospital to make and keep such records and that the records were made at the time such acts, transactions, occurrences, or events therein referred to occurred or arose or were made or within a reasonable time thereafter.

Vicky Finch

Sworn to subscribed before me this the 5 day of December, 2007.

Jessie Davis
NOTARY PUBLIC

My commission expires: 3-20-11

NORTHWEST MEDICAL CENTER

CONSENT FOR TREATMENT - CONDITIONS FOR ADMISSION

Patient Name _____ Case Number _____

Consent for Hospital Services: I am presenting myself for diagnoses and treatment at the Northwest Medical Center. I consent to the rendering of care, including but not limited to urine and blood tests, diagnostic procedures, x-rays, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff, employees, resident and staff physicians. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition.

Personal Valuables: The Northwest Medical Center is not responsible for money, jewelry, dentures, hearing aids, eye glasses, watches, credit cards, and other items which are not deposited in the Hospital safe.

Authorization to Release Information: I authorized Northwest Medical Center to release medical records, related medical information and charge information of this hospital visit for the purpose of determining insurance coverage and medical payment owed to the hospital for all or part of the hospital's charges, including but not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, or welfare funds and for purpose of continunity of care. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or the Medicaid Agency or its intermediaries any information needed for the Medicare or Medicaid claim. I consent to the release of information including psychiatric, drug, alcohol and substance abuse records.

Assignment of Benefits: I assign to Northwest Medical Center my right to payment under any policy of insurance providing coverage for such charges and direct that payment be made directly to the hospital. This authorization is given for all insurance benefits to which I may be entitled, whether designated as primary or secondary. I agree to cooperate fully with the hospital's efforts to obtain payment under any such policy and will execute any additional documents my insurance company may require in order to process the hospital's claim. In the event of any overpayment of insurance benefits (as where two policies are subject to coordination of benefits) I authorize the hospital to refund to the company making such overpayment.

Financial Responsibility: The undersigned patient/guarantor is ultimately responsible for payment of all charges regardless of whether the charges are or should have been covered by insurance. Payment in full is due at time of discharge as Northwest Medical Center does not extend credit for its services. Payment may be made by check, cash, money order, MasterCard or Visa. In the event payment is not received, this hospital bill may be placed with an attorney for collection in which case you shall be responsible for attorney's fees, costs and also interest on the unpaid balance at the legal rate. By signing this instrument you agree to waive all rights of exemption under Alabama law and any statute of the United States.

Physicians: Physicians including, without limitation, Emergency Room Physicians, Pathologists and Radiology Associates of North Alabama render services in our facilities. Their fees are not included in any hospital charges you may incur. You will be billed seperately for their services.

2-15-04 _____
Date

X _____
Patient's Signature

_____
Date

_____
Guarantor of Account and/or Insured

2-15-04 _____
Date

_____
Witness

ORIGINAL-MEDICAL RECORDS YELLOW-BUSINESS OFFICE PINK-DOCTOR OFFICE

FORM 7400/REVISED 11/2002 NORTHWEST MEDICAL CENTER

Northwest Medical Center
1530 Hwy 43, Winfield, AL 35594, (205) 487-7000

BARRON, TOMMY DURAN
WW0000260457

Adm Date: 02/15/04
Adm Time: 1434
Adm Source: EMERGENCY ROOM

Status: REG ER
Arrival: CAR
Ser/Loc: EMERGENCY DEPT.

Unit No: WW00020348
Rm/Bed:
FC: 01

PATIENT
Address:
[redacted] CHAPEL RD
[redacted] AL 35549
Phone: 205-924-0691
Soc Sec No 420-84-2332
County:

DOB	Age	Sex	MS	Race	Religion
06/21/57	46	M	M	W	

Employer: DISABLED

PT GUARANTOR
[redacted], TOMMY DURAN
Address: 2961 LEONARD CHAPEL RD
CARRON HILL,AL 35549
Home Ph: 205 924 0691
SS#: 420-84-2332
County:
Relationship to Patient: PATIENT

GUARANTOR EMPLOYER
DISABLED
Work Phone:
Occupation:

PERSON TO NOTIFY
BARRON,PATRICIA
2961 LEONARD CHAPEL RD
CARRON HILL,AL 35549
Home Phone: 205-924-0691
Work Phone:
Relationship to Patient: SPOUSE

INTAKE INFORMATION
Reason for Visit: FELL HURT RIGHT THUMB
Comments:
Admit Diagnosis: admit.diagnosis_____
Admitted by: WWADPWK

ACCIDENT INFORMATION
Nature of: FELL
OTJ: N
Where: HOME
Date: 02/14/04
Time: 1445

INSURANCE #1
MEDICARE A & B
PO BOX 830139
BIRMINGHAM AL 35283
1434
Policy #: 420842332A
Group: NONE - MEDICARE
Phone:
Insured DOB: 06/21/57
Subscriber: BARRON,TOMMY DURAN
Rel to Pt: PATIENT
Contact:

INSURANCE #2
Policy #:
Group:
Phone:
Insured DOB:
Subscriber:
Rel to Pt:
Contact:

INSURANCE #3
Policy #:
Group:
Phone:
Insured DOB:
Subscriber:
Rel to Pt:
Contact:

PRINCIPAL DIAGNOSIS

SECONDARY DIAGNOSIS

Principal Operation/Procedure

Secondary Operation/Procedure

DISCHARGE INFORMATION
Date:_____
Time:_____
Disposition:_____

PHYSICIANS

ER Physician	HCIS	Admitting Physician	HCIS	Family Physician	HCIS
McBride,Douglas					

Signature of Attending Physician:_____ Date:_____

[redacted]ORTHWEST MEDICAL CENTER
Emergency Department
Nursing Assessment and Flow Sheet

Prehospital Care by

IV Site Rate

cc remaining

Emergent Cat 1 ___
Urgent Cat 2 ___
NonUrgent Cat 3 ___

Arrival Mode: ___ Car
___ EMS
___ Stretcher
___ Other

Date: 3/11/14 Triage Time: 1420

Patient Number Accompanied by: Wife

Patient Name: Farrow Tommy **Primary Physician** None

Allergies: NKDA

Chief Triage Note: C/O injury (R) thumb, states fell yesterday striking. Dorsal

Triage Nurses Signature: R Farrow **Disposition:** B **Time:** 1430

Medications:

Zyrtec
Prednisone
Albuterol 2.5 q daily
Norco 10/325

Medication List attached to Chart: Yes No

Last Tetanus Last Flu Vaccine Oct 2013 Last Pneumonia Vaccine Oct 2013

Current on Immunizations per parents? Yes No

Vital Signs:

Time	BP	HR	RR	Temp.	SPO2
1420	146/99	98	18		

Smoker? Yes No How much per day? 1PPD

Weight 225 Last Meal?

Height 6'2" Last BM?

LMP

Physician's Orders:

PHYSICIAN'S SIGNATURE:

ED Nursing Assessment and Flow Sheet

Nursing Assessment and Review of Systems

Respiratory	Cardiovascular	Gastrointestinal	Genitourinary	Pupils	Motor
✓ Adequate	✓ Normal	✓ Normal	✓ Normal	✓ PEARL	✓ Moves all Ext
___ Shallow	___ Abn Sounds	___ BS	___ Frequency	R___ L___ Pinpoint	
___ Labored	___ Irreg. Pulse	___ Absent BS	___ Urgency	R___ L___ Midposition	Unable to move
___ Hypervent	___ JVD	___ Tender	___ Discharge	R___ L___ Dilated	___ L Arm
___ Abd GS	___ Edema	___ Rigid	___ Dysuria	R___ L___ Fixed	___ R Arm
___ SOB	___ Pain	___ Distended	___ Burning		___ L Leg
___ Cough	_____	___ Pain	___ Inconti.		___ R Leg
___ Prod.		___ N___ V	___ Retention		___ Impaired Speech
___ Non-Prod		___ Diarrhea			___ Impaired Vision
___ Sputum		___ Constipation			___ Impaired Hearing
Color_____					

Mental Status	Emot. Status	Skin Color	Skin Moisture	Barriers that could effect learning	
✓ Conscious	___ Calm	✓ Normal	✓ Normal	✓ None	___ Language Barr.
___ Lethargic	✓ Anxious	___ Cyanotic	___ Dry	___ Vision	___ Notify Translator
___ Confused	___ Silent	___ Pale	___ Moist	___ Hearing	If Non-English speaking
___ Unconscious	___ Hysteric	___ Ashen	___ Diaph	___ Speech	
___ Oriented	___ Hostile	___ Flushed	**Turgor**	___ Weakness	**Self Care**
___ GS SCORE	___ Crying	___ Jaundiced	✓ Normal	___ Confusion	✓ Independent
			___ Decre.	___ Fractures	___ Needs help with baths, meals, dress

OutPatient Screening	Functional Screening	Abuse Screen
___ Emaciated Appearance	___ Pt has new onset impaired mobility/balance affecting ADL and patient is without home resources to assist	___ Yes ✓ No Patient a victim of abuse?
___ Pt has major Trauma		___ Yes ✓ No Signs of symptoms of abuse?
___ Pt has daily alcohol intake		Describe:
___ Pt has major/chronic GI Dx		
___ Pt has poor appetite >7 days		✓ Yes ___ No Do you feel safe at home?

Social/Discharge Planning Screen	TB Screening	
___ Pt with a lack of financial resources to meet care requirements	___ Persistent Cough	___ TB Skin Test (+) Pt or family
___ Pt unable to actively understand and participate in healthcare needs and does not have home/family resources	___ Bloody Sputum	***If item 1-8 checked or Item 7 alone notify infection control or MD
	___ Unexpected or Unintentional weight loss	
	___ Night Sweats	
	___ Fever	✓ None identified

Discipline Consulted:_____Dietary_____Rehab (MD must order consult)_____Social Services

Pain Assessment

Do you have pain now? ✓ Yes ___ No Pain in Recent past? ✓ Yes ___ No Explain if yes.

Pain Scale: 8 0-10 FLACC _____ Wong Baker_____ Worst Pain Gets? 10 Best Pain Gets? 5

Describe Location of pain R thumb Onset of pain Yesterday Duration of pain Constant

What is an acceptable level of pain? 1-2 Quality of pain?_____Sharp _____Dull _____Cramping _____Aching

What are your Pain Expectations? _____What Relieves or Worsens your Pain? Movement

Are you Currently taking medications for pain? ___ Yes ✓ No Does it help? ___ Yes ✓ No

Pain Interferes with Activity/Movement ✓ Yes _____No Accompanying Symptoms _____Yes ✓ No

Patient Educational Material Provided ✓ Yes _____No Instructed to Report Pain to Nurse ✓ Yes _____No

Glascow Coma Scale

Spontaneous	4	Oriented	5	Obeys Commands	6
To Voice	3	Confused	4	Localized Pain	5
To Pain	2	InApp Words	3	Withdraws to Pain	4
None	1	InComp Words	2	Flexion to Pain	3
		None	1	Extension to Pain	2
Total GCS_____				None	1

IV FLUIDS

Time	IVF	Rate	Size	Site	Initial
Time					
Time					
Time					
Time					

IV MEDICATIONS:

Time	Medications		Dose	S/R
Time				
Time				
Time				
Time				

PO/IM/SQ Medications

Time	Medication	Route	S/R	Initial
Time				
Time				
Time				
Time				
Time				
Time				
Time				
Time				

PO/IM/SQ Medications Continued

Time	Medication	Route	S/R	Initials
Time				
Time				
Time				
Time				
Time				
Time				
Time				
Time				

Nursing Documentation

Time	Remarks - Medications - Signature
2~~3~~7	In X-ray
1440	MD to see BJ
310	MD to review X-ray
340	Splint + ace applied
350	D/C home

TIME	REMARKS - MEDICATIONS SIGNATURE

Admitted To:	**Transferred To:**
Room #	Room #
Valuables with? Patient Family	Report Called to:
Locked in Safe None	Accepting MD:
Report to:	Family aware of transfer? Yes No
Time of D/C 3:50p	Discharged with? Self (Family) EMS

D/c'd to: ~~Home~~ **Expired** **Body Released to:** **Funeral Home**

Nurse Signature: R Durrer

Discharge Instruction Sheet? (Yes) No

Discharged with instructions for follow-up care, Patient verbalizes

Understanding of Said Instructions: Verbal Written (Both) (Yes) No

Condition At Discharge: Critical Guarded (Stable)

RX Given	(Yes)	No
Driver	(Yes)	No
Work Excuse	Yes	(No)

Patient Signature: X Tommy Barron

09

Northwest Medical Center

EMERGENCY PHYSICIAN RECORD
Hand or Wrist Injury (4)

_____

Name Barrett, Tammy

Date 2/15/04 Age 47

TIME SEEN: 1400 ROOM: 2 __ EMS Arrival

☐ SEEN (ALSO) BY NP / PA _____

HISTORIAN: __patient __spouse __paramedics _____

__HX / __EXAM LIMITED BY: _____

HPI **chief complaint:** Injury to right / left
hand wrist forearm elbow arm
thumb index f. middle f. ring f. small f.

duration / occurred:
__just prior to arrival
__today
__yesterday
_____ days PTA

where:
__home __school
__neighbor's __park
__work __street
_____

context: __fell __blow __incised __crushed __burn

severity of pain: __mild __moderate __severe

pain level: current: _____/10 max: _____/10

location of injury:
R UE hand palm fingers
L UE hand palm fingers

ROS __tingling / numbness distally __suspected FB in skin lac
__painful / unable to bear weight __recent illness _____

PAST HX __negative R / L HANDED __prior injury
__other problems _____

Meds- __none / __see nurses note _____

Allergies- __NKDA / __see nurses note _____

☐ Nursing Assessment Reviewed ☐ Tetanus immun. UTD
☐ BP, HR, RR, Temp reviewed

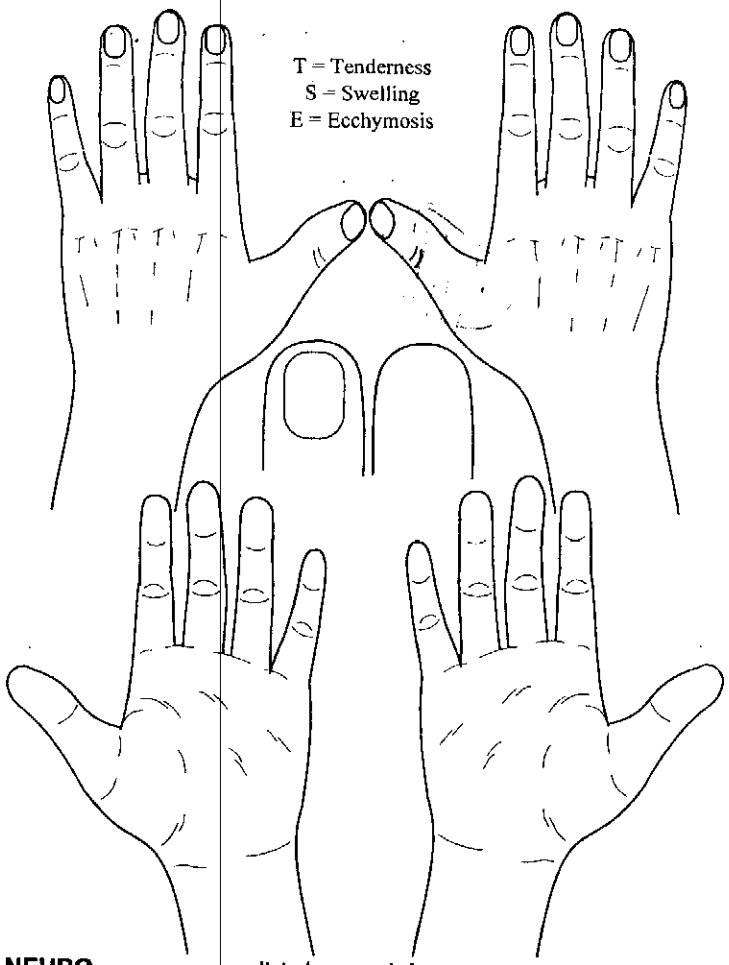
PHYSICAL EXAM

__Alert _____

Distress- __NAD __mild __moderate __severe

HAND
__nml inspection
__non-tender
__see diagram _____
__tenderness *soft-tissue / bony* _____
__swelling / ecchymosis _____
__limited ROM _____
due to: pain / functional deficit
__deformity _____
__nail injury _____
complete / partial avulsion subungal hematoma

WRIST
__nml inspection
__non-tender
__nml ROM
__see diagram _____
__tenderness *soft-tissue / bony* _____
__tenderness in anatomical snuff box _____
__wrist pain on axial thumb load _____
__swelling / ecchymosis _____
__limited ROM _____
__deformity _____



NEURO
__sensation intact
__motor intact

__digital nerve deficit _____
decreased fine touch abnml 2-point discrim.
__median nerve deficit _____
sensory deficit- lat. 3 ½ fingers / lat palm
motor deficit- pronation / thumb flexion
index & middle finger flexion
__ulnar nerve deficit _____
sensory deficit- med. palm / med. 1 ½ fingers
motor deficit- thumb adduction / fingers adduct.
__radial nerve deficit _____
motor deficit- wrist drop / thumb extension

VASCULAR
__no vascular compromise

__pallor / cool skin / abnml cap refill _____
__pulse deficit *radial ulnar* _____

TENDONS
__tendon function normal

__tendon visualized / injury seen _____
extensor flexor complete partial
__deficit in tendon function _____
limited extension limited flexion

FOREARM / ELBOW / ARM
__uninjured
__above wrist
__see diagram
__tenderness *soft-tissue / bony*
__swelling
__ecchymosis
__deformity
__limited ROM

SKIN
__warm, dry
__diaphoretic / cool / cyanotic

HEAD / ENT
__nml inspection
__pharynx nml
__tenderness
__swelling / ecchymosis

NECK / BACK
__nml inspection
__non-tender
__tenderness
__swelling / ecchymosis

CHEST
__no resp. distress
__non-tender
__breath snds nml
__tenderness
__swelling / ecchymosis

ABDOMEN
__non-tender
__no organomegaly
__tenderness / guarding

XRAYS ☐Interp. by me ☑Reviewed by me ☐Discsd w/ radiologist

R / L hand wrist forearm _____ finger

__normal / NAD
__no fracture
__nml alignment
__no foreign body
__DJD
__dislocation
__soft-tissue swelling
__foreign body
__fracture

Rt wrist 2nd MP

Other *study:*

☐See separate report

PROCEDURES and PROGRESS:

__splint *Velcro OCL / Ortho-glass / Plaster Aluminum-foam*
Volar Thumb spica Ulnar Wrist Sugar-Tong Cock-up Colles
splint & swathe
__applied by ED Physician / Orthopedist / Tech
__examined post splint application *NV intact alignment good*
__fingers buddy-taped
__digital block *lidocaine 1% ___cc marcaine 0.25% 0.5% ___cc*
__subungal hematoma drained using electrocautery
__foreign body removed *with forceps with incision*

Wound Description / Repair

length_____**cm location**_____
NVT __intact __see NVT exam (front side)
depth/shape/contamination
__superficial __linear __^stellate __contused tissue
__SQ __^irregular __nail avulsed
__muscle __^flap
__clean __contaminated *minimally / moderately / *heavily*
*with*_____

ANESTHESIA __LET / TAC __local __digital / metacarpal block
__lidoc 1% 2% epi / bicarb __marcaine .25% .5% epi

WOUND PREP
__Betadine
__irrigated / washed w/ saline
*minimal / mod. / *extensive*
__wound explored
__foreign material removed
partially completely
__debrided
minimal / ^mod. / ^extensive
__undermined
minimal / mod. / ^extensive
__^wound margins revised
__^multiple flaps aligned

WOUND REPAIR
*Wound closed with: wound adhesive / steri-strips*_____
SKIN- #_____ _____-0 nylon / prolene / staples_____
__interrupted __running __simple __mattress (h / v)
NAIL BED #_____ _____-0 vicryl _____
__interrupted __running __simple __mattress (h / v)
OTHER #_____ _____-0 material_____
__interrupted __running __simple __mattress (h / v)

*may indicate intermediate repair ^may indicate intermediate or complex repair

*Time*_____ __unchanged __improved __re-examined

__Rx given_____
__referred to / discussed with Dr._____
will see patient in: *office / ED / hospital in* _____*days*

CLINICAL IMPRESSION: *Fall* *Alleged Assault*

Contusion R / L wrist hand
Hematoma thumb index f. middle f. ring f. small f.
Laceration MP PIP DIP joint
Sprain / Strain / Dislocation
Fracture R / L radius *distal / shaft / proximal*
ulna *prox / shaft / distal / styloid* Colles' fx
metacarpal fx *# 5 4 3 2 1*
phalanx *# 5 4 3 2 thumb*
prox / middle / distal / tuft

CONDITION- ☐ stable ☐ improved ☐ unchanged
DISPOSITION- ☐ home ☐ admitted ☐ transferred

☑ Nursing assessment reviewed

*PHYSICIAN SIGNATURE-*_____
☐Template complete

NORTHWEST MEDICAL CENTER

U. S. Highway 43 P.O. Box 130
Winfield, AL 35594
205-487-7000

NORTHWEST MEDICAL CENTER
PATIENT RIGHTS AND RESPONSIBILITIES/ADVANCE DIRECTIVES ACKNOWLEDGMENT FORM

The Federal Government through the Patient Self-Determination Act 42 U.S.C. 1995 cc (F) of 1990 requires all hospitals to provide information and document in the medical record of each patient if they have executed a "Living Will".

The definition of a "Living Will" or Advance Directive is a declaration of your wishes with regard to providing or withholding various medical treatments in the event you should become in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery and you are unable to make treatment decisions on your own behalf.

I acknowledge that I have received the Notice of Privacy Practices for **Northwest Medical Center** and understand that my individually identifiable health information may be used and disclosed to carry out treatment, payment, or health care operations.

_____ NO I have already received a copy of the Notice of Privacy Practices and do **not** want another copy at this time.

Check here ✓ if you prefer to make your name, room #, general condition **available** for release to any Persons asking for you by name.

Check here _____ if you prefer that your health information, including your name, room #, and general condition be **withheld** from the facility directory

_____ YES My name may be given to clergy if they ask for me by name. My specific religious preference is _____. I understand that visitation by a clergy member of this denomination is not guaranteed.

✓ YES I would like to appoint Patricia Baron as a personal representative who is authorized to make decisions about the use and disclosure of my Health Information.

_____ NO I do not want to appoint a personal representative to make decisions about the use and disclosure of my Health Information.

X [signature] [illegible]
Signature of Patient/Guardian Date 2-15-04

[signature]
Witness Date 2-15-04

Diagnostic Imaging Report

Northwest Medical Cen - 1530 HWY 43 - P.O. Box 130
Phone #: (205)487-7748 Fax #: (205)487-7199

Name: BARRON,TOMMY DURAN Loc: WW.ER Radiology No: 00010025

Dob: 06/21/1957 Age: 46 Sex: M Status: DEP ER Unit No: WW00020348

Phys: MCCDO - McCurdy,Donald Acct: WW0000260457

Reason For Exam: INJURY TO (r) THUMB Exam Date: 02/15/2004

Exams: **CPT::**
000011722 HAND RT, AP/LAT/OBL 73130

Right Thumb
Indication: Injury to right thumb

Findings:
Two views of the right thumb were performed. A vertical fracture line is seen along the ulnar aspect of the proximal thumb phalanx distally. The frature line extends to the articular surface of the IP joint. Minimal displacement is noted at the fracture site although I see no evidence of off-set along the articular surface. Also noted is a linear lucency seen along the lateral aspect of the distal radius which appears to extend just below the cortical margin of the distal radial articular surface. I see no evidence of off-set along the articular surface of the radius. Also noted is diffuse osteopenia involving the hand. No radiopaque foreign body is identified.

IMPRESSION:
1. **ACUTE FRACTURE INVOLVING THE THUMB, PROXIMAL PHALANX AS DESCRIBED ABOVE WITH INTRARTICULAR EXTENSION.**
2. **POSSIBLE FRACTURE ALONG THE STYLOID PROCESS OF THE RADIUS. CLINICAL CORRELATION AND DEDICATED WRIST VIEWS ARE RECOMMENDED.**

** Electronically Signed by William Abbott on 02/16/2004 at 1646 **
Reported by: WILLIAM B. ABBOTT, III, M.D.
Signed by: Abbott,William

Cc: Douglas McBride; Donald McCurdy; RAD BILLING COMPANY

Technologist: SHERRI BROOKS, RT
Transcribed Date/Time: 02/16/2004 (1128)
Transcriptionist: WWRDJWS
Printed Date/Time: 02/16/2004 (1647) Batch No: N/A

NORTHWEST MEDICAL CENTER

DISCHARGE INSTRUCTION SHEET

PATIENT'S NAME: Tommy Barron | PATIENT'S NUMBER: | DATE: 2-15-04

NOTE: The examination and treatment you received in the Emergency Service Department has been rendered on an emergency basis only and is not intended to be a substitute for or an effort to provide complete medical care. Often additional treatment is necessary and should be provided by your family doctor or the physician to whom you have been referred. (A copy of your records and test reports will be sent to the physician.) Report to the physician any new or remaining problems because it is possible that all elements of the injury or illness may not be recognized and treated in a single visit.

Meanwhile, FOLLOW THE INSTRUCTIONS BELOW as indicated for you.

WOUND / SUTURE CARE

- ☑ Keep wound clean and dry.
- ☐ Report to your doctor if swelling, pus, foul smell, numbness, fever or discoloration develops.
- ☐ Keep wound covered with sterile bandage.
- ☐ If dressing needs to be changed,
  - ☐ Reapply sterile dressing.
  - ☐ Return to the ED within 2 days.
- ☐ Stitches / steri strips to be removed in ______ days.

SPRAIN, FRACTURE AND BRUISE CARE

- ☑ Apply ice pack every 3 hrs. for 15 mins., during first 24 hours.
- ☑ Apply heat every 4 hrs. for 15 mins., after 24 hrs. of ice.
- ☑ Keep injured part elevated and at rest.
- ☐ Keep cast clean and dry.
- ☐ Move finger/toes every hour while awake.
- ☐ Report to your doctor immediately if swelling, bleeding, pus, foul smell, numbness, fever or discoloration develops.
- ☐ You may walk on the cast after ______ hrs.
- ☐ Use crutches for ______ days.
- ☐ Ace wrap until pain free.
- ☐ Gait training given and performed.
- ☐ Wear sling/splint for ______ days.

HEAD INJURY CARE

- ☐ Rest for ______ hrs.
- ☐ [illegible] liquids for ______ hrs.
- ☐ [illegible] for ______ days.
- ☐ Report to your doctor immediately if any of the following occur:
  - [illegible] headaches.
  - [illegible] or fluid drains from nose or ears.
  - [illegible] vision.
  - [illegible] become irregular.
  - [illegible] legs.
  - [illegible]
  - [illegible] drowsiness [illegible] every 2 hrs for 24 hrs.)

PEDIATRICS

- ☐ Infants and small children, with fever, vomiting and diarrhea can become dehydrated (dried-out) quickly and require extra fluids.
  - (A). Jello
  - (B). Soda pop - let it go "flat" first.
  - (C). Clear juices (gatorade).
  - (D). Popsicles.
  - (E). Water.
- ☐ Do not drink milk until diarrhea stops, then dilute milk (½ skim and ½ water).
- ☐ Small amounts of cola soft drinks (Cokes, Pepsi, R.C., etc.) with the fizz out, may be frequently given to the child with persistent vomiting. Give small amounts every 15 - 20 minutes.
- ☐ For fever, you may give your child ______________ every ______ hours.
- ☐ If the fever rises to 103°F orally or 104°F rectally, the temperature should be brought down with a sponge bath using moderately warm water. Do not use alcohol or cold water.
- ☐ Use light clothing and covers to allow body heat to escape. If the child complains about being chilly, he may have another blanket or two, but remove extra covers when the chills have passed.
- ☐ If any problems arise, notify your family doctor. If you are unable to reach him or in doubt, feel free to call the Emergency Department.

MEDICATIONS

- ☐ PRESCRIPTIONS GIVEN AND WHEN TO TAKE THEM:

Darvocet N[illegible]

FOLLOW-UP APPOINTMENTS

- ☑ Follow-up with your family physician.
- ☐ Return for wound check in ______ days.
- ☐ Return to the Emergency Department for suture removal in ______ days.
- ☐ Follow-up with family physician for suture removal in ______ days.

ADDITIONAL INSTRUCTIONS

WORK/SCHOOL STATEMENT

- ☐ Able to work/Go to school/Resume previous activities.
- ☐ Limit activity ______ days

Able to return to work/Atten school: ____/____/____

ALL X-RAYS ARE REVIEWED BY A RADIOLOGIST. YOU WILL BE NOTIFIED IF THEIR INTERPRETATIONS DIFFER FROM THE INTERPRETATIONS OF THE EMERGENCY PHYSICIAN WHO TREATED YOU. PLEASE PROVIDE A NUMBER WHERE YOU CAN BE REACHED.

[illegible] have been informed of and understand all of the instructions given to me and [illegible] thereof. I have been instructed to contact a physician as soon as possible for [illegible] and care if indicated. I do not have any more questions at this time, but [illegible] call the Emergency Department at any time should I have any further questions [illegible] follow-up care.

PATIENT'S SIGNATURE: Tommy Barron

Nurse Signature: [illegible]

Physician Signature: [illegible]